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Issue Date: 02 July 2004

Case No. 2003-LHC-02589

OWCP No. 5-113626

In the Matter of

THELBERT WEAVER,
Claimant
v.

NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY,
Self-Insured Employer

Appearances:
Gregory E. Camden, Esq., for Claimant
Benjamin M. Mason, Esq., for Employer

Before:
RICHARD E. HUDDLESTON
Administrative Law Judge

DECISION AND ORDER

This proceeding involves a claim for temporary total disability from an injury alleged to have been suffered by Claimant, Thelbert Weaver, covered by the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. §901 *et seq*. (Hereinafter referred to as the "Act"). Claimant alleges that he was injured while climbing a set of stairs while employed by Employer, and that as a result he is suffering from an injury to his back.

The claim was referred by the Director, Office of Workers' Compensation Programs to the Office of Administrative Law Judges for a formal hearing in accordance with the Act and the regulations issued thereunder. A formal hearing was held on March 1, 2004. (TR).[1] Claimant submitted four exhibits, identified as CX 1 through CX 4, which were admitted without objection. (TR. at 5). Employer submitted five exhibits, EX 1 through EX 5, which were admitted without objection. (TR. at 6). The parties also submitted one joint exhibit, JX 1, which was admitted. (TR. at 5). The record was held open until May 3, 2004, for briefs. Claimant submitted his brief on May 3, 2004. Employer filed its brief on May 17, 2004, along with a motion for an extension of time in which to file its brief. Claimant has not objected; therefore, Employer's motion is granted, and Employer's late brief is accepted.

[1] EX-Employer's exhibit; CX-Claimant's exhibit; and TR-Transcript.

The findings and conclusions which follow are based on a complete review of the record in light of the argument of the parties, applicable statutory provisions, regulations, and pertinent precedent.

ISSUE

The sole issue disputed by the parties is whether Claimant is entitled to temporary total disability from January 20, 2003, through September 16, 2003.

STIPULATIONS

At the hearing, Claimant and Employer stipulated, and I find:

1. That an employer/employee relationship existed at all relevant times;

2. That the parties are subject to the jurisdiction of the Longshore & Harbor Workers' Compensation Act;

3. That the claimant suffered an injury to his back on March 29, 2002;

4. That a timely notice of injury was given by the employee to the employer;

5. That a timely claim for compensation was filed by the employee;

6. That the employer filed a timely First Report of Injury with the Department of Labor and a timely Notice of Controversion;

7. That the claimant's average weekly wage at the time of his injury was $1,106.51 resulting in a compensation rate of $737.67;

8. That the claimant was paid temporary total disability benefits for 5/16/02; 6/7/02 to 6/10/02; and 8/27/02 to 9/8/02 at the rate of $737.67, and an award can be entered for this time;

9. That the claimant's treating physician for injury is Dr. Warren Foer.

(JX 1).

DISCUSSION OF LAW AND FACTS

Testimony of Claimant

Claimant is fifty-one years old and has been employed by Employer for thirty-two years. Claimant has Type II diabetes, for which he takes medication. (TR. at 22). When his injury occurred on March 29, 2002, Claimant was working as an HVAC technician, a position in which he repaired, maintained, and installed heating and ventilation air-conditioning systems. (TR. at 12-13). Claimant testified that he was injured when he was climbing a set of incline steps while returning to his job after lunch. He felt a sharp pain on the right side of his lower back, which made it painful to walk, stand, or sit in on position for too long. Claimant testified that he did not have any pain in his legs at the time the injury occurred, but that his right leg started hurting approximately one week later. (TR. at 13-14).

Claimant saw Dr. Foer on July 8, 2002. According to Claimant, Dr. Foer was not one of the three doctors that were presented to him from which to choose, but that upon his request, he was permitted to see Dr. Foer. (TR. at 14). Initially, Dr. Foer provided no treatment, but did run a series of tests, including two MRIs. (TR. at 14). Dr. Foer took Claimant out of work for a few brief periods of time and returned him to work after the last period of time on September 9, 2002. When Claimant returned to work, he was still under physical restrictions as to lifting, bending, and climbing, and was still having leg pain. (TR. at 15).

Claimant returned to Dr. Foer's office on January 20, 2003, upon direction from the clinic; according to Claimant, he "just couldn't tolerate the pain anymore. I worked with the pain before that time during the remaining of the year with pain medication just about every day, and it got to the point that I just couldn't stand it anymore." (TR. at 15-16). Claimant testified that the pain he was experiencing on January 20, 2003, was different from that which he experienced in September, 2003, because, while he still had some pain on the right side, the pain had also moved from his right to his left side. According to Claimant, the pain moved from the right to left side on approximately January 17, and that the pain consisted of numbness and weakness. He also had problems standing, walking, bending, and stooping. (TR. at 16, 20-21).

Claimant testified that Dr. Foer conducted another MRI, which came back negative. Thereafter, Dr. Foer recommended that Claimant see a neurologist for a second opinion. Claimant saw Dr. Barot in July, 2003; according to Claimant, the examination lasted for ten to fifteen minutes. Claimant stated that, after Dr. Barot had reviewed Claimant's medical records, he diagnosed a severe back strain. (TR. at 17-18). According to Claimant, the pain in his right leg had increased again by the time he saw Dr. Barot. (TR. at 21). Claimant also saw Dr. Skidmore; that examination lasted approximately fifteen to twenty minutes. (TR. at 19-20).

Claimant returned to work on September 17, 2003, after telling Dr. Foer that his back had improved and that he was ready to return to work. According to Claimant, his back started to get better during the latter part of August. The leg pain had gone away, as had the numbness and weakness. Claimant testified that he still has some pain in his low back occasionally, for which he takes pain medication. (TR. at 18, 22-24). When Claimant returned to work, he was doing the same job he performed prior to his injury, with a restriction of limited bending. Claimant

testified that this prevents him from doing his job to "a certain extent" but that he is not currently having any trouble doing his job. (TR. at 19).

Medical Evidence

On April 24, 2002, Dr. Daniel S. Kothmann performed an MRI Lumbar Spine without contrast on Claimant at the referral of Dr. Steven Apostoles from Employer's clinic. Dr. Kothmann noted Claimant's clinical history of back injury and pain. Dr. Kothmann found normal lumbar vertebral bodies as far as height, alignment, and signal intensity. Dr. Kothmann also noted "The conus medullaris is unremarkable and terminates at the L1 level." Dr. Kothmann saw no evidence of disc herniation, canal stenosis, or neural foraminal narrowing, and saw no intraspinal masses. Dr. Kothmann's impression was "Unremarkable MRI of the lumbar spine." (EX 3).

Dr. Foer informed Employer on July 8, 2002, that Claimant was seen in his office on that date for a neurosurgical evaluation, as requested by Employer. Dr. Foer noted the circumstances surrounding Claimant's accident on March 29, 2002. He also noted that Claimant's predominant pain was in his right lower back, and that this pain occurred upon prolonged standing, bending, or straining. Claimant also related to Dr. Foer that he had a feeling of numbness in his thigh at times that continued to his foot and toes intermittently. Claimant was also experiencing occasional weakness in his right leg. Claimant denied any problems with his left leg. (CX 2-5). Dr. Foer wrote that Claimant had had an MRI scan of his lumbar spine in April, 2002, which revealed neither abnormalities in lumbar spine nor a herniated disc. The X-rays of Claimant's lumbar spine showed some mild degenerative changes at the right sacroiliac joint, which was where Claimant described his predominant pain. Claimant was taking Darvocet for pain. (CX 2-5, 2-6).

In his neurologic examination, Claimant had some tenderness in the right sacroiliac joint "but no sciatic notch tenderness and no specific spinous tenderness." Claimant's lumbar range of motion "showed some modest restriction with pain at the right sacroiliac joint with right lateral bending." Dr. Foer found no sciatic radicular pain on Claimant's straight leg raises. Dr. Foer noted "no focal neurologic findings in terms of motor testing. Strength is intact. There was no atrophy." Claimant's sensory examination was intact as well. Dr. Foer's impression was that Claimant's features were "more of a right sacroiliac joint strain." Dr. Foer stated that he believed that Claimant's condition may include a diabetic component. Dr. Foer recommended that Claimant have a sacroiliac joint specific injection if he had not had one already. Dr. Foer additionally recommended an EMG and nerve conduction studies. Dr. Foer concluded that he found no evidence of a compressive radiculopathy, and that Claimant was capable of working with restrictions against working in confined spaces, prolonged bending, and heavy lifting. Dr. Foer noted that these restrictions would be temporary until a further assessment could be made. (CX 2-6).

By letter dated August 19, 2002, Dr. Foer informed Employer that Claimant underwent an EMG and nerve conduction studies. These studies showed evidence of "a mild S1 radiculopathy on the right." Dr. Foer noted that Claimant continued to have pain radiating down his right leg in a radicular fashion. Dr. Foer wrote, "This, with a previously negative MRI scan,

is somewhat disconcerting," and also noted that the MRI was conducted only a short time after the onset of the pain. In Dr. Foer's experience, often an MRI conducted later would show evidence of a herniated disc or lesion; therefore, he recommended another MRI scan because of the continuing discomfort and positive EMGs. (CX 2-4).

On August 22, 2002, Dr. John W. Pinkston performed an MRI on Claimant's lumbar spine at the referral of Dr. Foer. Dr. Pinkston noted Claimant's clinical history of right leg pain and numbness. Dr. Pinkston found no fractures, destructive lesions, or other acute bony abnormalities. Claimant's conus medullaris was unremarkable, and his discs were normal in height and hydration. Dr. Pinkston found no disc herniation, spinal canal lateral recess, or foraminal stenosis. Dr. Pinkston noted "No etiology for a radiculopathy is demonstrated." Dr. Pinkston's impression was, "Unremarkable MR scan of the lumbar spine, unchanged since a study of 4/22/02." (EX 4).

In a letter dated September 5, 2002, Dr. Foer wrote to Employer that Claimant had returned to his office and had another MRI of the lumbar spine. The MRI noted no structural abnormality that would produce the right lower extremity radiculopathic pain. Dr. Foer also found nothing that correlated with the electromyographic abnormalities Claimant was experiencing. However, Dr. Foer did note that on electrical studies, Claimant had evidence of "some mild right S1 changes in the nerve root." Dr. Foer opined that there was nothing further that he could recommend as far as additional studies. He recommended to the clinic that Claimant's situation be monitored and that he be returned to light duty work beginning on September 9, 2002. Dr. Foer concluded by stating that if Claimant's right pain did not subside, the next option would be a myelogram CT scan. (CX 2-3).

By letter dated January 20, 2003, Dr. Foer informed Employer's medical clinic that Claimant had returned to his office. At that time, Claimant related that the pain on the right side of his low back was less persistent and that the pain in his right leg had diminished until one week prior. At that time, Claimant stated that the pain "suddenly and acutely shifted over to the left side and down the left lower extremity. He has continued to have that left lower extremity radiculopathy." Dr. Foer noted that Claimant had an antalgic gait. He also noted that Claimant had "positive straight leg raising sign on the left side at around 30-40 degrees." Dr. Foer opined that Claimant needed another MRI scan of the lumbar spine in light of his change in condition. (CX 2-2).

On January 20, 2003, Dr. Foer completed a Work Status form for Claimant. He noted that Claimant was totally disabled on that date and would be unable to return to work until further notice. (CX 2-7).

On January 20, 2003, Dr. Kothmann performed a second MRI without contrast on Claimant's lumbar spine. Dr. Kothmann noted Claimant's clinical history of low back and left leg pain. Again, Dr. Kothmann found normal lumbar vertebral bodies as far as height, alignment, and signal intensity, and found the conus medullaris to be unremarkable. He also found no evidence of disc herniation, canal stenosis, or neural foraminal narrowing, and saw no intraspinal masses. Dr. Kothmann's impression was that the examination remained unchanged from the MRIs on April 24, 2002, and August 22, 2002. (EX 5).

By letter dated February 3, 2003, Dr. Foer wrote to Employer's medical clinic that Claimant had returned to his office and underwent an MRI of his lumbar spine. Dr. Foer reported that he was unable to discern a specific lesion, and that the radiologist was unable to discern the cause of Claimant's low back and left leg pain. As Dr. Foer was unable to determine the cause of Claimant's pain, he recommended that Claimant have a neurological evaluation to determine whether there was a medical cause for his problem. (CX 2-1).

By letter dated February 12, 2003, Dr. Grant A. Skidmore of Neurological Specialists, Inc., informed Employer that Claimant was seen by him on February 10, 2003. In the letter, Dr. Skidmore recounted Claimant's account of his injury on March 29, 2002, as well as Claimant's history of treatment, including epidural steroid injections, MRIs, EMG, and pain management. Claimant related to Dr. Skidmore that he was unable to walk without a cane, as the cane took pressure off of his low back. Claimant's pain was in his left low back and into the left leg, and at times into the foot. Claimant had some numbness and swelling in his left foot at times. (EX 1(a)).

Upon examination, Dr. Skidmore noted that Claimant had a normal gait, but was limping slightly on his left leg. His neurological examination was normal. Claimant's reflexes and motor strength were normal. Claimant had no coordination problems. He had decreased sensation over his left lower extremity, which "follow[ed] no dermatomal distribution." Dr. Skidmore also noted that "On straight leg raising, he reports pain into each leg at 60 degrees." (EX 1(a)). Dr. Skidmore reviewed the MRI from January 20, 2003, and found that the MRI yielded normal results. He also reviewed the EMG from August 6, 2002, and found "mild acute right S1 radiculopathy and no evidence of neuropathy." Dr. Skidmore diagnosed that Claimant was "one year out from lumbar strain, with continued complaints." Dr. Skidmore thought Claimant's prognosis "from the lumbar strain standpoint is excellent. The mechanism of injury is mild, and he is a year out. I do not think any lingering problems he is having is a result of that." Dr. Skidmore stated that no treatment would benefit Claimant at this point other than continued pain management. Therefore, Dr. Skidmore concluded that Claimant did not need any work restrictions, but that "if he has an issue with that, a functional capacity evaluation may be obtained to place objective testing on subjective reports." (EX 1(b)).

Dr. A.J. Barot saw Claimant on July 16, 2003, for a second opinion upon referral from the Department of Labor. Claimant related the details of his injury to Dr. Barot, as well as the fact that he had two MRIs and electrodiagnostic testing performed. Claimant noted to Dr. Barot that he has been treated with medications, continued to have pain in his back, and was unable to function normally. (EX 2(a)). Dr. Barot examined Claimant and noted no evidence of atrophy upon motor examination. Claimant's motor strength was normal in all four extremities. Claimant's straight leg raising was limited to 70 degrees on the right side and 80 degrees on the left side. Dr. Barot noted that "[s]ensory examination was inconsistent, but there was suggestion of possible decrease in sensation in the left lower extremity, the particular sensations affected were pinprick and temperature." Dr. Barot observed that Claimant was slightly unstable when standing on his right foot alone, but had no problems standing on his left foot. Dr. Barot wrote that he had no medical records or MRI films to review. In order to make a decision as to what

treatment, if any, might be needed, Dr. Barot stated that he would have to review the films and test results as well as what kind of technique had already been offered to him. (EX 2(b)).

Dr. Barot saw Claimant again on August 18, 2003. Dr. Barot noted that he received Claimant's MRI films of the lumbosacral spine (including films from April, 2002, and that from January, 2003). Dr. Barot also reviewed the results of the electrodiagnostic testing. Dr. Barot wrote that "I am unable to put together the finding of S1 radiculopathy on the right side and patient's symptoms on the left side. I do believe that these things do not make too much sense. While the patient certainly sustained a significant back sprain, enough time has passed to reach maximum benefit." Therefore, Dr. Barot concluded that Claimant should be able to resume his normal physical activities, with the occasional use of pain medication. Dr. Barot also stated that "it may be helpful to have a psychological evaluation performed" on Claimant. (EX 2(c)).

On September 17, 2003, Dr. Foer completed a Work Status form for Claimant. He noted that Claimant could return to full duty work on that date, with a restriction on bending. (CX 2-8).

By letter dated January 13, 2004, Dr. Foer informed Claimant's attorney that he recommended, after examining Claimant on January 20, 2003, that Claimant remain out of work until his condition had sufficiently improved. When he evaluated Claimant again on September 17, 2003, Claimant's low back pain and radicular pain syndrome had resolved, and therefore, he cleared Claimant to return to work. Dr. Foer concluded that Claimant was unable to work between January 20, 2003, and September 17, 2003. (CX 4-1).

Deposition of Dr. Warren Foer

Dr. Foer's deposition was taken on January 26, 2004. Dr. Foer stated that his specialty was neurological surgery and that he had been Board certified in that field since 1971. Dr. Foer began treating Claimant on July 8, 2002, for his March 29, 2002, accident, and has examined Claimant several times since then. (CX 3-4). Claimant related to Dr. Foer that he began feeling a "pulling pain" in his lower back when he was climbing up a very steep incline ladder. Claimant related to him that the pain increased the day following the accident, particularly when he was standing, bending, or straining, and then he began experiencing pain and numbness in his right leg. The numbness emanated from his right thigh and extended intermittently into his foot. Claimant also told Dr. Foer that the shipyard clinic had sent him to other physicians for evaluations and that he had been administered epidural steroid injections for the pain, but that the pain continued. (CX 3-5, 3-6). Additionally, Claimant had had an MRI scan performed in April, 2002, and was told that there were no abnormalities present. Dr. Foer received a copy of this MRI and reviewed it; he saw no abnormalities as well. Dr. Foer noted that, in addition to Claimant's statements, he also received Claimant's records, which confirmed Claimant had been seen by Dr. Mark Newman and had received injections. (CX 3-6).

Dr. Foer performed a neurological examination of Claimant and found no neurological abnormalities, including no focal weakness. Dr. Foer did note that Claimant had "sluggish reflexes," but he attributed that to Claimant's history of diabetes as opposed to a specific neurological disorder. Dr. Foer did find tenderness over the right sacroiliac joint, but found no

evidence of a radicular component. Dr. Foer's impression was that Claimant had a right sacroiliac joint strain. (CX 3-7). At that time, Dr. Foer recommended work restrictions, an EMG, electrodiagnostic studies, nerve conduction studies, and consideration of a sacroiliac joint injection. (CX 3-9, 3-10).

Dr. Foer explained that the sacroiliac joint is part of the pelvic bone, where the spine joins the pelvis. He also explained that radiculopathy could result from a number of causes, with one of the most common being a type of discogenic problem that compresses the nerve root near where the nerves pass through the spine. (CX 3-8). There are both objective and subjective methods to determining whether a radiculopathy is present. According to Dr. Foer, historical factors and a physical examination are important factors to consider, as are mechanical factors such as certain movements along the spine. (CX 3-9, 3-10). Dr. Foer also pointed out that some diabetes patients sometimes have mononeuropathies due to diabetes, in which they will occasionally have specific nerves that become inflamed and cause pain. (CX 3-9).

The tests that Dr. Foer ordered were performed on August 6, 2002. They showed that there was no diabetic effect, but did show "some right first sacral nerve-root involvement" at S1. These results were revealed by the EMG, and highlighted a different area than Dr. Foer's initial impression at the sacroiliac joint. (CX 3-11). Claimant returned to Dr. Foer's office on August 19, 2002, to discuss the testing results. At that time, Claimant told Dr. Foer that he was experiencing more pain shooting down his leg, which Dr. Foer noted was consistent with a radicular fashion. Based upon this fact and the results of the electrical studies, Dr. Foer recommended another MRI scan; that scan was conducted on August 22, 2002. (CX 3-12, 3-13). Dr. Foer reviewed the results of the MRI but found no "compressive lesion," despite the positive results of the electrodiagnostic EMG study (which were consistent with Claimant's complaints of pain), which Dr. Foer pointed out was a very sensitive test. (CX 3-13, 3-14).

Claimant returned to Dr. Foer's office on September 5, 2002, and was continuing to have pain. Dr. Foer testified that at that time, Claimant's shooting-type pain appeared to be radicular, but that given the abnormal electromyographic studies, Dr. Foer could not appreciate a structural cause of the pain. (CX 3-14). Dr. Foer discussed with Claimant that they needed to just wait and watch the pain, or that a myelogram CT scan, which is another neurodiagnostic study used to evaluate spinal problems, could be conducted. Dr. Foer recommended the former suggestion, and at that point placed Claimant on light-duty work restrictions. (CX 3-15).

Dr. Foer next saw Claimant on January 20, 2003. Claimant indicated that his condition had changed in that he was now experiencing the shooting pain in his left leg along with some discomfort in his right side. Dr. Foer testified that Claimant had not previously complained of left leg pain. (CX 3-16, 3-26). Claimant related to Dr. Foer that this condition arose suddenly, but did not state to Dr. Foer that anything specific had brought on the pain. Dr. Foer began looking for any cause of the pain, and did not limit his investigation to the possible causes that he had previously explored. However, Dr. Foer did state that the pain in the left leg would not arise from the right sacroiliac joint or from the S1 joint. (CX 3-17). Claimant had another lumbar spine MRI on January 20, 2003; Dr. Foer again found no abnormalities on that MRI. (CX 3-18). Therefore, Dr. Foer was unable to discern a reason for Claimant's pain. (CX 3-19).

Claimant returned to Dr. Foer's office on February 3, 2003, at which time Claimant was continuing to have low back pain and left leg pain. Dr. Foer explained to Claimant that he did not know what was causing his pain. (CX 3-19). Dr. Foer recommended that Claimant see a medical neurologist to see if there was some type of inflammatory basis for his pain. (CX 3-20). Following this visit, Dr. Foer testified that he placed Claimant under the restrictions of no heavy lifting, no bending, and no work in tight or confined spaces. Dr. Foer stated that he included these restrictions in a letter to Aetna insurance that he wrote on that date. (CX 3-24).

Dr. Foer next saw Claimant on September 17, 2003. Dr. Foer recalled that at that time, Claimant's pain had gone away and that Claimant had been seen by Dr. Barot, a neurologist. Claimant related to Dr. Foer that he understood that Dr. Barot made no neurological finding, and that in the preceding month, Claimant's pain had resolved. (CX 3-20 through 3-22). Dr. Foer examined Claimant and found no problems of back pain or nerve-root irritation, nor did he find any neurological problems on either Claimant's right or left side. (CX 3-22). Dr. Foer was unaware that Claimant had seen Dr. Skidmore. (CX 3-20).

Dr. Foer testified that between January 20, 2003, and September 17, 2003, he felt Claimant should remain out of work. (CX 3-25). He also placed Claimant under physical restrictions preventing him from engaging in heavy lifting, bending, and working in tight or confined spaces. (CX 3-24). Dr. Foer released Claimant to return to work on September 17, 2003. Dr. Foer originally placed no physical restrictions on Claimant. However, when he was given a copy of the return to work form, Claimant inquired of Dr. Foer regarding a restriction on bending. Dr. Foer concurred that a restriction on bending would be appropriate and amended Claimant's copy of the form, but not the copy of the form in Claimant's file. (CX 3-23). However, Dr. Foer indicated that, had he seen Claimant in the preceding month when his pain subsided, he may have moved up the date on which Claimant could have returned to work. (CX 3-25). Dr. Foer has not seen Claimant since September 17, 2003, but stated that, if Claimant were doing well, he "was probably conditioned enough with an appropriate exercise program to go back to unrestricted work." (CX 3-28, 3-29).

When asked whether he believed Claimant's left side pain were related to the incident on March 29, 2002, Dr. Foer opined that "All I can say is it's a mirror image of what he was complaining about, only it's on the opposite side." He also stated that, "What that process that caused leg pain in March of '02, why it shifted to the left side, I think is still part and parcel of the same general package." (CX 3-26 through 3-28). Additionally, Dr. Foer stated that he thinks that the period of disability in 2003 was historically tied to the March 29, 2002, incident. (CX 3-29). Dr. Foer went on to state that "[T]o this day I don't know what the process is that caused his leg pain. . . . And I don't know whether Dr. Skidmore found a – or what Dr. Barot's statement is. I never saw those records other than Mr. Weaver indicating to me that nothing was discerned by Dr. Barot." (CX 3-27).

Dr. Foer stated that he has now had a chance to review the reports by Drs. Skidmore and Barot, but that nothing in the reports changed any of the opinions he offered. (CX 3-28, 3-29). Dr. Foer found similar neurological findings in their reports to those he found. (CX 3-30). Dr. Foer still felt that Claimant was totally disabled from January 20, 2003, based on his evaluation, the results of the electrodiagnostic test, and Claimant's pain pattern. (CX 3-29). The only

difference between his findings and those of Drs. Skidmore and Barot was that "Dr. Skidmore reported a finding of decreased sensation in the left leg in a nondermatomal pattern." This latter phrase denotes that it is "not following any nerve-root pattern. It's generally a non-organic functional finding." Dr. Foer further explained that the term "nondermatomal pattern" also meant that the problems were not consistent with any injury to the nervous system. (CX 3-30 through 3-32). Dr. Foer went on to state that this was "an emotional finding" and that, to this extent, this may be why Dr. Barot recommended a psychological evaluation. (CX 3-31).

Section 20(a) Presumption

Section 20(a) of the Act provides a claimant with a presumption that his condition is causally related to his employment if he shows that he suffered a harm and that employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated the condition. *See U.S. Indus./Fed. Sheet Metal, Inc. v. Director, OWCP*, 455 U.S. 608, 614-15 (1982); *Merrill v. Todd Pac. Shipyards Corp.*, 25 BRBS 140, 144 (1991); *Gencarelle v. General Dynamics Corp.*, 22 BRBS 170, 174 (1989), *aff'd*, 892 F.2d 173 (2d Cir. 1989). Claimant's credible subjective complaints of symptoms and pain can be sufficient to establish the elements of physical harm. *Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981), *aff'd sub nom. Sylvester v. Director, OWCP*, 681 F.2d 359 (5th Cir. 1982). However, as the Supreme Court has noted, "[t]he mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer." *U.S. Indus.*, 455 U.S. at 615. Once the claimant has invoked the presumption, the burden of proof shifts to the employer to rebut it with substantial countervailing evidence. *Merrill*, 25 BRBS at 144. If the presumption is rebutted, the administrative law judge must weigh all the evidence and render a decision supported by substantial evidence. *See Del Vecchio v. Bowers*, 296 U.S. 280, 286 (1935).

Claimant argues in his post-hearing brief that he has sustained his burden of proof and has established a prima facie case of disability through his testimony that he had no back pain or injury prior to the March 29, 2002, work accident. Claimant also offers that following the accident, he experienced pain at first in right leg, and then in his left leg. (Claimant's Brief, at 9). Claimant also points to Dr. Foer's deposition testimony and his opinion that Claimant's right and left leg problems relate to the March 29, 2002, injury. Claimant offers several reasons why Dr. Foer's opinion should be accepted. First, Claimant contends that Dr. Foer's opinion is consistent, in that he relies on Claimant's history and the results of a series of tests in reaching his conclusion. (Claimant's Brief, at 9). Claimant also contends that an exact etiology of his problem need not be reached in determining whether Claimant has established a prima facie case for disability. (Claimant's Brief, at 9-10).

Claimant testified that on March 29, 2002, he was climbing a set of incline steps when he felt a sharp pain on the right side of his lower back, which made it painful to walk, stand, or sit in one position for too long. Claimant also testified his right leg started hurting approximately one week after the accident. (TR. at 13-14). The medical records show that Claimant provided a similar account of his accident to the physicians who subsequently examined him, including Dr. Foer, who served as his treating physician. On July 8, 2002, Claimant told Dr. Foer that he had pain in his lower back. (CX 2-5). Claimant was returned to work on September 9, 2002, but

returned to Dr. Foer's office on January 20, 2003. At that time, he was experiencing some pain in his right side and also was experiencing pain in his left leg. (CX 2-2; 2-3).

To invoke the presumption, all that a claimant must show is that he suffered a harm and that employment conditions existed or a work accident occurred that could have caused, aggravated, or accelerated his condition. The parties have stipulated that Claimant's employment is subject to coverage under the Longshore and Harbor Workers' Compensation Act. It is also undisputed that Claimant sustained an injury on March 29, 2002. (*See* JX 1). Claimant credibly testified that he experienced pain following the accident and that he began experiencing additional pain in January, 2003, after he had been released to return to work in September, 2002. Claimant's medical records confirm his testimony.

Upon consideration of the evidence as well as the stipulations entered into by the parties, I find that Claimant has established a prima facie case for compensation and is entitled to the presumption of Section 20(a) that his condition is causally related to the injury he sustained on March 29, 2002. The burden of proof then shifts to Employer to rebut the presumption with substantial countervailing evidence.

Rebuttal of Section 20(a) Presumption

Since the presumption has been invoked, the burden now shifts to the employer to rebut the presumption with substantial countervailing evidence that establishes that the claimant's employment did not cause, aggravate, or accelerate his condition. *Swinton v. J. Frank Kelly, Inc.*, 554 F.2d 1075, 1082 (D.C. Cir. 1976); *Peterson v. General Dynamics Corp*., 25 BRBS 71, 78 (1991); *James v. Pate Stevedoring Co.*, 22 BRBS 271, 273 (1989). Substantial evidence is relevant evidence such that a reasonable mind might accept it as adequate to support a conclusion. *Richardson v. Perales*, 402 U.S. 389, 401 (1971); *Universal Camera Corp. v. Nat'l Labor Relations Bd.*, 340 U.S. 474, 477 (1951); *Consol. Edison Co. v. Labor Bd.*, 305 U.S. 197, 229 (1938).

The employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by Section 20(a). *Dearing v. Director, OWCP*, 998 F.2d 1008, at *2, 27 BRBS 72, 75 (4th Cir. 1993) (unpublished) (per curiam); *Steele v. Adler*, 269 F. Supp. 376, 379 (D.D.C. 1967); *Smith v. Sealand Terminal, Inc.*, 14 BRBS 844, 846 (1982). Rather, the presumption must be rebutted with specific and comprehensive medical evidence proving the absence of, or severing, the connection between the harm and the employment. *See Am. Grain Trimmers, Inc. v. Director, OWCP*, 181 F.3d 810, 817-19 (7th Cir. 1999); *Hampton v. Bethlehem Steel Corp.*, 24 BRBS 141, 144 (1990).

The employer may also rebut the presumption with negative evidence, but again, negative evidence must be "specific and comprehensive enough to sever the potential connection between a particular injury and a job-related event." *Swinton*, 554 F.2d at 1083. An employer cannot rebut the presumption on the basis of suppositions or equivocal testimony. *Dewberry v. S. Stevedoring Corp.*, 7 BRBS 322, 325 (1977), *aff'd mem.*, 590 F.2d 331 (4th Cir. 1978). Rather, an employer must show either facts or negative evidence that is both specific and comprehensive

to overcome the presumption. If the employer presents specific and comprehensive evidence sufficient to sever the connection between a claimant's harm and his employment, the presumption no longer controls, and the issue of causation must resolved on the whole body of proof. *See Del Vecchio v. Bowers*, 296 U.S. 280, 286 (1935); *Volpe v. Northeast Marine Terminals, Inc.*, 671 F.2d 697, 700 (2d Cir. 1981); *Leone v. Sealand Terminal Corp.*, 19 BRBS 100, 102 (1986).

Employer argues that the Section 20(a) presumption has been rebutted based upon Dr. Skidmore's findings that Claimant's left leg problems were not related to the March 29, 2002, injury. Specifically, Employer cites to Dr. Skidmore's finding of no abnormalities upon examining Claimant on February 10, 2003, and the fact that Dr. Skidmore stated Claimant could return to work at that point. Employer also contends that Dr. Barot's opinion also contributes to severing the causal connection between Claimant's injury and left leg problems. Employer argues that Dr. Barot reviewed Claimant's medical records and also examined Claimant, but was unable to reconcile the right side radiculopathy with the problems of the left side. According to Employer, Dr. Barot also stated that Claimant could return to work without restrictions. (Employer's Brief, at 14-15).

Employer notes that none of the three physicians who examined Claimant were able to find a cause for Claimant's complaints. Employer points out that while both Drs. Skidmore and Barot concluded that Claimant's left side pain was unrelated to the March 29, 2002, injury, Dr. Foer opined that "Claimant's complaints must be related to the March 29, 2002 incident because he can come up with no other explanation." (Employer's Brief, at 15). Employer also cites to Dr. Foer's testimony that he is still unable to determine the etiology of Claimant's complaints in terms of structural change, as well as Dr. Foer's statements that Claimant's left side problems are a mirror image of those he had on the right. Employer contends, however, that Dr. Foer never reached a conclusion as to what exactly was causing Claimant's right side problems. Employer also points out that what Dr. Foer thought could be the cause of the right side problems, specifically the right sacroiliac joint and problems with the S1 disc, are not things that could explain Claimant's left side pain. (Employer's Brief, at 16). Therefore, Employer argues that even though Dr. Foer is Claimant's treating physician, his opinion that the right and left side problems must be related is not enough to show that the left side problems are related to the March 29, 2002, injury. (Employer's Brief, at 17).

Claimant argues that Employer has not rebutted the Section 20(a) presumption with sufficient or substantial evidence. According to Claimant, the opinion of Dr. Skidmore is not sufficient to rebut the presumption because Dr. Skidmore saw Claimant only once, was not his treating physician, and was not able to evaluate and examine Claimant on a consistent basis. Claimant also notes that Dr. Skidmore never gave his opinion as to whether Claimant was able to work during the period of time for which Claimant seeks total disability benefits. Claimant also argues that the presumption cannot be rebutted on the basis of Dr. Barot's opinion. While Dr. Barot opined that Claimant could return to work, he also recommended a psychological examination for Claimant; Dr. Barot never addressed whether Claimant has been or is disabled due to his condition, but only states that as of August 19, 2003, Claimant could return to work. (Claimant's Brief, at 10).

Based upon the evidence submitted by Employer, I find that Employer has met its burden of rebutting the Section 20(a) presumption with substantial countervailing evidence such that the presumption of compensability has been overcome. Employer's medical evidence is specific and comprehensive and severs the potential connection between the harm and employment. Employer has produced the opinions of two physicians who unequivocally state that Claimant's left leg problems are not related to his March 29, 2002, injury. Dr. Skidmore reviewed the MRI from January 20, 2003, as well as the August 6, 2002, EMG, in addition to examining Claimant. He concluded that Claimant's problems were not a result of his lumbar strain on March 29, 2002. (EX 1). Dr. Barot undertook a similar course in evaluating Claimant's condition. In his physical examination of Claimant, he did note an inconsistent sensory examination with a possible decrease in sensation in the left lower extremity. However, upon review of Claimant's MRIs from April, 2002, and January, 2003, as well as the results of his electrodiagnostic testing, Dr. Barot concluded that he was unable to reconcile Claimant's S1 radiculopathy on his right side with the problems that he was experiencing on his left side, and therefore opined that Claimant was able to return to his normal physical activities. (EX 2(c)).

It is well established that "[t]he unequivocal testimony of a physician that no relationship exists between a claimant's disabling condition and the claimant's employment is sufficient rebuttable evidence" to overcome the Section 20(a) presumption. *Flood v. NAF Billeting Branch*, 134 F.3d 363 (4th Cir. 1998) (table decision) (citing *Kier v. Bethlehem Steel Corp.*, 16 BRBS 128, 129-30 (1984)). Further, the Board has clearly noted that that an employer is not required to establish another agency of causation in order to rebut the Section 20(a) presumption. *O'Kelley v. Dep't of the Army/NAF*, 34 BRBS 39, 41 (2000) (per curiam).

While it is true, as Claimant states, that Dr. Skidmore examined Claimant only once and was not his treating physician, this does not eliminate the fact that Dr. Skidmore *did* physically examine Claimant as well as his MRI and EMG results in reaching his conclusion. Claimant also argues that the presumption cannot be rebutted on the basis of the opinions of Drs. Barot and Skidmore because they did not offer opinions as to whether Claimant was able to work during the period for which he is claiming total disability. While this may very well be true, Claimant's argument is misplaced at this juncture of deciding whether the presumption has been rebutted. The matter under scrutiny at this point is whether Claimant's employment caused, aggravated, or accelerated his condition, not whether he was totally disabled during the period he claims.

Because I find that Employer has rebutted the Section 20(a) presumption, the presumption no longer controls, and the issue of causation must be resolved on the whole body of proof.

Weighing the Evidence

As stated above, because the presumption no longer controls, the evidence must now be examined and weighed as to the issue of causation. *Del Vecchio v. Bowers*, 296 U.S. 280, 286 (1935). The presumption "never had and cannot acquire the attribute of evidence in the claimant's favor." *Id*. Therefore, it must be determined whether Claimant has shown by a preponderance of the evidence that the alleged injury is causally related to his employment with Employer. 5 U.S.C. §556(d) (2002); *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267,

277 (1994) (citing *Steadman v. SEC*, 450 U.S. 91, 95 (1981)); *Devine v. Atl. Container Lines, G.I.E.*, 25 BRBS 16, 20-21 (1990).

As to the issue of causation, Claimant argues that he was injured on March 29, 2002, when he was climbing a set of steep incline steps and felt a sharp pain in his lower back. Claimant experienced pain in his right leg soon thereafter and began treating with Dr. Foer for that pain. Claimant was taken out of work for several periods of time, and finally returned to work in September, 2002. Claimant states that in January, 2003, he returned to Dr. Foer's office, this time complaining of pain in his left leg. (Claimant's Brief, at 4). Claimant testified that he "just couldn't tolerate the pain anymore" and that he "worked with the pain before that time during the remaining of the year . . . and it got to the point that I just couldn't stand it anymore." (TR. at 15-16). Claimant described this pain as numbness and weakness, which caused him problems standing, walking, bending, and stooping. (TR. at 16, 20-21).

Claimant has also offered his medical records from his course of treatment with Dr. Foer, as well as Dr. Foer's deposition testimony to sustain his position. Dr. Foer's notes indicate that he reviewed Claimant's MRI and X-rays. While the MRI showed no abnormalities, the X-rays showed mild degenerative changes at the right sacroiliac joint (the area in which Claimant described his predominant pain to Dr. Foer). Dr. Foer also performed a neurological examination of Claimant and found some tenderness and restriction at the right sacroiliac joint. As to the right leg, Dr. Foer diagnosed a right sacroiliac joint sprain. (CX 2-5, 2-6). Dr. Foer next ordered an EMG (which Dr. Foer explained in his deposition was a very sensitive test), and nerve conduction studies, which evidence of a mild radiculopathy at S1 on the right. Given the inconsistent results, Dr. Foer ordered another MRI, which showed no etiology for a radiculopathy. (CX 2-3). Claimant was thereafter returned to work on September 9, 2002.

Dr. Foer's records show that when Claimant returned to his office on January 20, 2003, Claimant informed the doctor that the pain had moved from the right to the left leg. (CX 2-2). An MRI of Claimant's lumbar spine revealed no changes since the two previous MRIs. Dr. Foer informed Employer that he was unable to discern a cause of Claimant's low back and left leg pain, and so recommended a neurological consultation. (CX 2-1). On September 17, 2003, Dr. Foer allowed Claimant to return to work with a restriction on bending. (CX 2-8).

In his deposition, Dr. Foer corroborated Claimant's account of the March 29, 2002, incident and the back and leg pain that he experienced thereafter. (CX 3-5). He also explained that when Claimant returned to his office in January, 2003, he began looking for any cause of the pain and did not limit his investigation to the possible causes that he had previously explored, other than to specifically note that the pain in the left leg would not result from the right sacroiliac joint or the S1 joint. (CX 3-17). Claimant returned to Dr. Foer's office on February 3, 2003, at which time Dr. Foer explained to him that he did not know what was causing the pain and recommended that Claimant see a neurologist. (CX 3-20). By the time Claimant returned to Dr. Foer's office on September 17, 2003, the pain had resolved. Dr. Foer found no neurological problems on examining Claimant and returned him to work. (CX 3-20). Dr. Foer confirmed during his deposition that Claimant should have remained out of work between January 20, 2003, and September 17, 2003, while at the same time indicating that, had he seen Claimant one month

prior, when Claimant told him that the pain had resolved, he may have returned Claimant to work sooner. (CX 3-25).

Finally, Dr. Foer reiterated his opinion that Claimant's right and left leg problems all stemmed from his March 29, 2002, injury, though he could not specifically state what was causing the pain. He emphasized that Claimant's left leg problems were the mirror image of those he experienced with his right leg. (CX 3-26, 3-27, 3-28). As to the reports of Drs. Skidmore and Barot, Dr. Foer testified that their neurological findings were the same and did not cause him to change his opinion. (CX 3-28, 3-29, 3-30).

As evidence that Claimant's left leg problems were not caused by the March 29, 2002, injury, Employer has offered the medical reports of Drs. Skidmore and Barot as well as three MRI reports. All three of the MRI reports were unremarkable as to the lumbar spine. Dr. Kothmann performed two of the MRIs (April 24, 2002, and January 20, 2003) and noted virtually identical results. Dr. Pinkston performed the August 22, 2002, MRI, with results similar to those found by Dr. Kothmann. (EX 3; EX 4; EX 5).

Dr. Skidmore examined Claimant as well as his MRI from January 20, 2003, and his EMG from August 6, 2002. Dr. Skidmore concurred with Dr. Kothmann that the MRI yielded normal results. He gave no opinion as to whether he agreed with the results of the EMG. Dr. Skidmore's notes indicate that Claimant gave a consistent and accurate report of his injury and treatments prior to seeing Dr. Skidmore. On examination, Dr. Skidmore found that Claimant's neurological examination was normal, but that he did have decreased sensation over his left lower extremity that followed "no dermatomal distribution." In the end, Dr. Skidmore concluded that none of the problems Claimant was then experiencing were a result of the March 29, 2002, incident and that Claimant would not benefit from further treatment. (EX 1).

Dr. Barot reached a similar conclusion. He also examined Claimant, finding normal motor strength and no atrophy. Dr. Barot also detected an inconsistent sensory examination, particularly a decrease in sensation in the left lower extremity. Dr. Barot deferred making a diagnosis until he reviewed Claimant's MRIs and medical records, including the results of his electrodiagnostic testing. Once these were reviewed, Dr. Barot concluded that he was unable to reconcile the right side radiculopathy with the symptoms on the left side, and that Claimant should be able to resume his normal activities. (EX 2).

Upon consideration of all of the evidence, I find that Claimant has established by a preponderance of the evidence that the problems he experienced with his left leg were the result of the March 29, 2002, injury. In reaching this conclusion, I find that Dr. Foer's opinion is entitled to greater weight than the opinions of Drs. Barot and Skidmore. Only the qualifications of Dr. Foer are known, as he testified that he has been Board certified in the field of neurological surgery since 1971. He is also the treating physician and was in the unique position of monitoring Claimant when he was having problems with his right leg. Therefore, Dr. Foer has a stronger basis on which to compare the symptoms of both sides when Claimant presented himself in January, 2003. Also, no evidence of any intervening accident or injury, or of a previous accident or injury, has been introduced.

All three physicians made the same neurological findings, yet differed in their conclusions. While both Drs. Barot and Skidmore examined Claimant and opined that his left side problems were not related to his March 29, 2002, injury, they both also noted a decrease in sensation in the left lower extremity. Neither Dr. Barot nor Dr. Skidmore provided much additional detail as to why their individual conclusions were reached. Dr. Skidmore offered that Claimant was a year removed from the accident, and Dr. Barot similarly opined that "enough time" had passed for Claimant to reach "maximum benefit." Dr. Foer, on the other hand, specifically noted that the symptoms in Claimant's left leg were a "mirror image" of the ones that presented in his right leg. While Dr. Foer is unable to pinpoint, as he phrases it, the "exact process" causing the problems, he nonetheless opines that the problems were related to the March 29, 2002, injury. Based upon his thirty-plus years of experience as a Board-certified neurological surgeon and his greater familiarity with Claimant's condition, I find that his opinion is entitled to greater weight. Thus, I find that Claimant has established by a preponderance of the evidence that his injury is causally related to his employment.

Nature and Extent of Disability

Claimant in this case seeks temporary total disability benefits commencing January 20, 2003, through and including September 16, 2003. Claimant does not contend that he has reached maximum medical improvement; therefore, he is entitled only to temporary compensation. *Berkstresser v. Washington Metro. Area Transit Auth.*, 16 BRBS 231, 234 (1984).

To establish a prima facie case of total disability, a claimant must show that he is unable to return to his regular or usual employment due to his work-related injury. *Trans-State Dredging v. Benefits Review Bd.*, 731 F.2d 199, 200 (4th Cir. 1984); *Newport News Shipbuilding & Dry Dock Co. v. Director, OWCP*, 592 F.2d 762, 765 (4th Cir. 1979); *Harrison v. Todd Pacific Shipyards Corp.*, 21 BRBS 339, 342-43 (1988); *Elliott v. C & P Tel. Co.*, 16 BRBS 89, 92 (1984). A claimant's credible testimony alone, without objective medical evidence, on the issue of the existence of a disability may constitute a sufficient basis for an award of compensation. *Eller & Co. v. Golden*, 620 F.2d 71, 74 (5th Cir. 1980); *Ruiz v. Universal Mar. Serv. Corp.*, 8 BRBS 451, 454 (1978). In addition, a claimant's credible testimony of the constant pain endured while performing work activity may constitute a sufficient basis for an award of compensation notwithstanding considerable evidence that the claimant can perform certain types of work activities. *Mijangos v. Avondale Shipyards, Inc.*, 948 F.2d 941, 945 (5th Cir. 1991).

Claimant testified that when he went to Dr. Foer's office on January 20, 2003, he "just couldn't tolerate the pain anymore. I worked with the pain before that time during the remaining of the year with pain medication just about every day, and it got to the point that I just couldn't stand it anymore." (TR. at 15-16). The pain consisted of numbness and weakness, and he had problems standing, walking, bending, and stooping. (TR. at 16, 20-21). Claimant went on to state that his leg pain, numbness, and weakness went away in late August, 2003, but that he still had low back pain occasionally. (TR. at 18, 22-24).

Claimant has also offered as proof of his total disability two work status forms completed by Dr. Foer. The first form removed Claimant from work on January 20, 2003, and the second

released Claimant to return to work on September 17, 2003. (CX 2-7, 2-8). Dr. Foer reaffirmed his opinion that it was proper for Claimant to be out of work between these dates in a letter to Claimant's counsel on January 13, 2004, and during his deposition. (CX 4-1, 3-25). When Claimant did return to work, Claimant was restricting from bending. (CX 3-23). Dr. Foer did testify, however, that had Claimant returned to his office earlier than September 17, 2003, and were doing well, he "probably" would have released him to return to work at that time. (CX 3-28, 3-29).

Employer argues that the evidence does not support Claimant's assertion that he was unable to work for the entire period for which he seeks temporary total disability. Employer asserts that Dr. Foer testified that Claimant could have returned to work in August, 2003, and that Dr. Skidmore stated Claimant could have returned to work on February 10, 2003. Employer also cites to Dr. Foer's testimony that he wrote to the insurance company regarding Claimant's work restrictions in February 2003, but never informed Employer of such. (Employer's Brief, at 17).

Based upon the testimony and the evidence presented, I find that Claimant was unable to work beginning on January 20, 2003. Claimant testified credibly about the pain in his left leg, and Dr. Skidmore's notes indicate that Claimant was unable to walk without the assistance of a cane, which helped take the pressure off of his low back. To this extent, however, I find that Dr. Skidmore's opinion that Claimant was able to return to work on February 10, 2003, to be inconsistent with the other evidence. In addition to being inconsistent with Claimant's testimony, Dr. Skidmore's opinion is inconsistent with that of Dr. Foer. Dr. Foer examined Claimant one week prior and recommended a neurological examination to determine the cause of Claimant's problem. The same day (February 3, 2003) Dr. Foer confirmed with Claimant's health insurance company the work restrictions for Claimant. The fact that Claimant could not walk without the assistance of a cane is strong proof that he was unable to work.

As to the length of time Claimant was totally disabled, Claimant credibly testified that his condition improved in the latter part of August. This comports with Dr. Barot's notes, which, unlike Dr. Skidmore's notes, do not contain any notations of Claimant using a cane to ambulate. Dr. Barot does note that on August 18, 2003, Claimant should be able to return to his normal physical activities with the occasional use of pain medication. Dr. Foer also testified that had Claimant returned to his office in an improved condition in August, 2003, he may have released him to work sooner. Based upon Claimant's own testimony and that by Dr. Foer, as well as the report of Dr. Barot, I find that Claimant was not totally disabled as of August 18, 2003.

Claimant has made a prima facie showing that he was totally disabled between January 20, 2003, and August 18, 2003. Thus, the burden shifts to Employer to show suitable alternate employment. *Trans-State Dredging v. Benefits Review Bd.*, 731 F.2d 199, 200 (4th Cir. 1984); *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128, 131 (1991). However, in the instant matter, Employer has produced no evidence on the issue of suitable alternate employment. Therefore, Claimant is considered to be and I find that he was totally disabled between January 20, 2003, and August 18, 2003.

Order

Accordingly, it is hereby ordered that:

1. Employer, Newport News Shipbuilding and Dry Dock Company, is hereby ordered to pay to Claimant, Thelbert Weaver, temporary total disability benefits for the periods of May 16, 2002; June 7, 2002 to June 10, 2002, inclusive; and August 27, 2002, to September 8, 2002, inclusive, at the compensation rate of $737.67 per week;

2. Employer, Newport News Shipbuilding and Dry Dock Company, is also hereby ordered to pay to Claimant, Thelbert Weaver, temporary total disability benefits for the period of January 20, 2003, to August 18, 2003, inclusive, at the compensation rate of $737.67 per week;

3. Employer is hereby ordered to pay all medical expenses related to Claimant's work related injuries;

4. Employer shall receive credit for any compensation already paid;

5. Interest at the rate specified in 28 U.S.C.§1961 in effect when this Decision and Order is filed with the Office of the District Director shall be paid on all accrued benefits and penalties, computed from the date each payment was originally due to be paid. *See Grant v. Portland Stevedoring Co.*, 16 BRBS 267 (1984);

6. Claimant's attorney, within 20 days of receipt of this order, shall submit a fully documented fee application, a copy of which shall be sent to opposing counsel, who shall then have ten (10) days to respond with objections thereto.

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RICHARD E. HUDDLESTON
Administrative Law Judge